

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW MEXICO

<i>Debra Boyce</i>	
DATE REC'D	<u>DEC 23 1991</u>
DATE APPV'D	<u>JAN 16 1992</u>
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HCFA 179	<u>91-23</u>
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REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS
FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State of New Mexico concerning advance directives. The state statutes are silent on the question of whether a health care provider may object, on the basis of conscience, to the implementation of advance directives.

A. Living will

New Mexico Statutory Act 24-7-1 through 24-7-11 is cited as the "Right to Die Act" and defines a living will as a document, executed by an individual of sound mind and having reached the age of majority, directing that if he is ever certified as suffering from a terminal illness or being in an irreversible coma, maintenance medical treatment shall not be utilized for the prolongation of his life.

The same statute discusses a variety of limitations of living will declaration. They are valid documents only if executed in the same process as a valid will under provisions of the Probate Code. Certification of terminal illness or irreversible coma must be done in writing by two physicians presumed to be acting in good faith. Revocation of the living will can be accomplished by destroying the document or by contrary indication expressed to any one witness over the age of majority.

The statute also defines proxy designation for the benefit of minors who are terminally ill or in irreversible coma. Substituted consent may also be given by all family members who can be contacted through reasonable diligence and who choose to forego treatment for their member.

Attachment 4.34-A (1) contains the "New Mexico Living Will and Declaration Under the Right to Die Act".

B. Durable Power of Attorney

New Mexico Statutory Act 45-5-501 through 45-5-502 defines durable power of attorney as a written document in which a principal designates another person as his attorney-in-fact or agent by a power of attorney containing the words, "This power of attorney shall not be affected by the incapacity of the principal",

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or "This power of attorney shall become effective upon the incapacity of the principal" or similar language showing the principal's intent that the authority conferred shall be exercised notwithstanding his capacity.

The second section of this statute explains that other powers of attorney are not revoked or terminated if the attorney in-fact, agent or other person acts in good faith without actual knowledge of the death or disability of the principle.

Attachment 4.34-A (2) contains the "New Mexico Durable Power of Attorney for Health Care Decisions" prepared in accordance with NMSA 1978 § 45-5-502.

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NEW MEXICO LIVING WILL

AND

DECLARATION UNDER THE RIGHT TO DIE ACT

I, _____, being of sound mind and age 18 or older, willfully and voluntarily make known my will and directive that my life shall not be prolonged under the circumstances set forth below, and do hereby declare:

1. If at any time I should be certified in writing by two physicians, one of whom is in charge of my care, to have a terminal illness or be in an irreversible coma, I direct that maintenance medical treatment be withheld or withdrawn, and that I be permitted to die.
2. By maintenance medical treatment, I mean any medical treatment that is designed solely to sustain the life process, but I do not mean medication administered for the purpose of easing pain and discomfort.
3. In the absence of my ability to give directions regarding the use of maintenance medical treatment, it is my intention that this directive shall be honored by my family and physicians as the final expression of my legal right to refuse medical treatment, and I accept the consequences of such refusal.
4. If my attending physician declines to participate in the withholding or withdrawal of maintenance medical treatment, she/he must take steps to transfer me to another physician who will honor my wishes.
5. I understand the full import of this directive, and I am emotionally and mentally competent to make this directive.
6. I understand that I may revoke this directive at any time by destroying it or saying so in the presence of someone over age 18.
7. I will keep the original of this document at:

(name the place or person who will have the original document)

I will give copies of this document to:

(name the place or person who will have copies of the document)

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_____ (your initials)

8. If there are any uncertainties or ambiguities about this directive, or the treatment that I should be given if I become incompetent, I request my physician to discuss the matter with _____, who knows my interests and values, and with whom I have discussed my wishes.
9. I offer this further expression of my wishes: (optional; you may use this space to indicate the kind of care you would want, or any medical treatments that you would or would not want)

Date

Signature

Address

This form must be witnessed below.

WITNESSES

We believe the person who signed this document to be of sound mind and under no constraint or undue influence.

On this _____ day of _____, 19 _____, the person who signed this document, _____, of _____ (street address), _____ (city), New Mexico, signed the foregoing document, consisting of two typewritten pages, in our sight and presence and declared the same to be his/her document under the Right to Die Act, and at his/her request and in his/her sight and presence and in the sight and presence of each other, we signed our names as witnesses.

Witness

Address

Witness

Address

NEW MEXICO DURABLE POWER OF ATTORNEY

FOR

HEALTH CARE DECISIONS

STATE	<u>New Mexico</u>
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The powers granted by this document are broad and sweeping. The document is prepared in accordance with NMSA 1978, §45-5-502, and should be interpreted consistently with that statute.

I, _____, reside in _____ County,
New Mexico. I appoint _____ to
serve as my legally-authorized decision maker(s).
Name(s)

If any decision maker appointed above is unable to serve, then I appoint
_____ to serve as my decision maker in place of the person who is
unable to serve.

Check and initial the following paragraph only if more than one person is appointed to act on your behalf and you want any one of them to have the power to act alone without the signature of the other(s). If you do not check and initial the following paragraph and more than one person is named to act on your behalf, then they must act jointly.

() _____ If more than one person is appointed to serve as my decision maker, then each may act alone and independently of each other.

My decision maker shall have the power to act in my name, place and stead in any way which I myself could do with respect to the following matters to the extent permitted by law:

Initial the box opposite each authorization which you desire to give to your decision maker. Your decision maker shall be authorized to engage only in those activities which are initialed. Cross out those authorizations you do not desire to give to your decision maker.

1. Decisions regarding lifesaving and life prolonging medical treatment ()
2. Decisions relating to medical treatment, surgical treatment,
nursing care, medication, and hospitalization ()

Superior - None

3. Decisions relating to residence in a nursing home
or other facility and home health care ()

4. Transfer of property or income as a gift to my spouse
for the purpose of qualifying me for governmental
medical assistance (i.e., giving my property to my
spouse so I will qualify for Medicaid). ()

5. List others related to health care ()

_____. ()
_____. ()
_____. ()

In making health care decisions for me, my decision maker should be guided by the following
expression of my wishes: (optional)

This power of attorney shall become effective only if I become incapacitated and shall terminate
upon my death unless I have revoked it prior to my death. By incapacity, I mean that, among other
things, I am unable effectively to make or communicate health or personal care decisions.

(Signature)

Dated: _____, 19 ____

This form must be notarized below.

ACKNOWLEDGEMENT

STATE OF NEW MEXICO)
) ss
COUNTY OF _____)

The foregoing instrument was acknowledged before me this _____ day of
_____, 19 ____, by _____.

Notary Public

My commission expires: _____